# Completion Instructions for MSA-1653-B

# Special Services Prior Approval - Request/Authorization

The MSA-1653-B must be used by Medicaid enrolled Medical Suppliers, DME Providers, Orthotists, Prosthetists, Hearing Aid Dealers and Hearing Cochlear Manufacturers. MDCH requests that the MSA-1653-B be typewritten to facilitate processing. Fill-in enabled copies of this form can be downloaded from the MDCH website www.michigan.gov/mdch >> Providers >> Information for Medicaid Providers >> Medicaid Provider Forms and Other Resources. The form is generally self-explanatory. Completion of boxes 2 through 27 is mandatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDCH website.

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| **Box 1** | MDCH Use Only |
| **Box 12** | Check Yes if beneficiary is in a Nursing Care Facility or No if the beneficiary is not in a Nursing Care Facility. If Yes, include the Nursing Care Facility name, address and phone number. |
| **Box 19** | Enter a complete description of the item requested, including manufacturer, model, style, etc. |
| **Box 20** | Enter the HCPCS Procedure Code |
| **Box 21** | Enter the applicable HCPCS Modifier |
| **Box 24** | Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). Provider Types 85 and 87 must submit the prescription/CMN with this form. |
| **Box 25** | Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested, other insurance coverage for services requested, etc. |

## Form Submission

PA request forms for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDCH - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: **(517) 335-0075**

To check the status of a PA request, contact the MDCH - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Michigan Department of Community Health
**SPECIAL SERVICES**
**PRIOR APPROVAL – REQUEST/AUTHORIZATION**

| 1. PRIOR AUTHORIZATION NUMBER (MDCH USE ONLY) |
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**The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.**

| 2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL) | 3. NPI NUMBER | | 4. PHONE NUMBER |
|---|---|---|---|
| 5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP) | | | 6. FAX NUMBER |
| 7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL) | 8. SEX ☐ M ☐ F | 9. BIRTHDATE | 10. MIHEALTH CARD NUMBER |
| 11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP) | | | |
| 12. DOES BENEFICIARY RESIDE IN A NURSING CARE FACILITY? ☐ **YES** ☐ **NO** **IF YES, PROVIDE** FACILITY NAME, ADDRESS, PHONE NUMBER. | | | |
| 13. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL) | 14. NPI NUMBER | | 15. PHONE NUMBER |
| 16. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP) | | | 17. FAX NUMBER |

| 18. LINE NO. | 19. DESCRIPTION OF SERVICE (INCLUDE BRAND NAME AND MODEL NUMBER WHERE APPLICABLE) | 20. PROCEDURE CODE | 21. MODIFIER | 22. QUANTITY | 23. CHARGE |
|---|---|---|---|---|---|
| 01 | | | | | |
| 02 | | | | | |
| 03 | | | | | |
| 04 | | | | | |
| 05 | | | | | |
| 06 | | | | | |
| 07 | | | | | |

| 24. ICD-9-CM DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES. | 25. REMARKS AND/ OR DOCUMENTATION OF MEDICAL NECESSITY |
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26. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR

27. PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAW.

PROVIDER SIGNATURE DATE

**MDCH USE ONLY**

| 28. REVIEW ACTION: | 29. CONSULTANT REMARKS |
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| APPROVED ☐ INSUFFICIENT DATA ☐<br>DENIED ☐ NO ACTION ☐<br>APPROVED AS AMENDED ☐ | |

CONSULTANT SIGNATURE DATE